



AHLTA and Data Entry A Provider's Perspective

Data Quality Management Course
May 18 - 20, 2010

AHLTA and Data Entry - A Provider's Perspective

Objectives

- A review of how an average provider views coded data and metrics
- Demonstrate issues regarding data entry into our outpatient systems
 - Clinical-centric data
 - Business-centric data
- Understand difference between “documentation” and “coding” to see why some data errors may arise



Warning!

Not every slide in my presentation is in your handout

The slides in the handout **are** in the correct order



What do military providers care about?

Well, let's start with what they don't care about:

- Correct coding for the pure, unadulterated joy of it
- Clicking as many boxes as possible on a form/screen
- Entering a lot of coded data to make someone else's life easier

Let's face it – Physicians are awfully expensive data entry operators!



Then what *do* military providers care about?

- What they say:

“We care about taking care of our patients!”

- What that translates to:

“We want to decrease pain and suffering.”

- Most often the pain and suffering is the patient's . . .
. . . But sometimes it's our own!

Which leads us to . . .



Metrics drive behavior

Metrics in Action

- Commander: “I want my facility to get as many Relative Value Units (RVUs) as we should to reflect the hard work we are doing”
- Business Office: “Facility RVUs is a product of number of encounters times the RVUs/encounter. We should increase the RVUs/encounter to increase facility RVUs”
- Clinic Chief: “We have a lot of t-cons that are worth very few RVUs, and that brings our RVU/encounter down. So admin-out all of the t-cons so that our RVU/encounter goes up”

This occurred at a facility I visited. The focus in a clinic on a single metric (RVU/Encounter) drove a behavior that the Commander *never* meant to have happen!



Common Provider Metrics

- Empanelment
- Number of patients seen each day/week/month
- Number of no-shows
- Patient Satisfaction
- HEDIS compliance
- RVUs/visit
- RVUs/day

As a “lowly” provider, there are relatively few that I can directly impact.



Clinical Data

Clinical Data

In AHLTA, clinical data can be separated into a few broad categories:

- Data from the S/O module (subjective/objective data)
- Data from A/P Module (diagnoses, procedure codes, orders)
- Data from free-text areas of the AHLTA encounter
- Data from everything else
 - Vitals
 - Questionnaires
 - Results for labs, meds, radiology
 - Etc, etc

Clinical Data

■ S/O notes = Medcin

Past, Social and Family Hx have 2 potential levels (pertinent and complete). A pertinent contains at least 1 type of history (Past, Social or Family) -> (99214)
A complete for a new patient requires all 3 types of history (Past, Social and Family) to be documented. None required for a 99213.

Past Medical History (1) Note: Any 1 of the 3 history items in burgundy will give 1 credit towards Past Hx

☒ **Current Medications** : Current medications reviewed and reconciled.
☒ Medication list reviewed with patient, reconciliation completed, and list given to patient.
☒ Noncompliance With Meds ☐ ☒ Hx of Cancer

☒ **Medical History** : reviewed

☒ **Surgical History** : reviewed

☒ **Review of Immunizations** : up to date

☒ **Social History (1)** : reviewed
Denies ☒ Tobacco ☒ Alcohol

☒ **Family History (1)** : reviewed

Information Source: ☒ Patient ☐ Other: **Reliability of source:** ☐ ☐

Branch of Service: ☒ USA ☐ USN ☐ USAF ☐ USMC **Status:** ☒ Active Duty ☐ Reservist ☐ Retired

☒ Visit Is Deployment-related ☐ If YES, please type in the Location of Deployment
☒ Visit Is GWOT-related ☐ NOTE: Use for resource management tracking of visits.

Learning and Understanding ☒ Learning Disability (barriers to learning)

Vitamins/Herbals/OTCs ☒ Taking Vitamin Supplements ☐ Taking OTC Medications ☐

☒ vomiting ☒ abdominal pain ☒ diarrhea

Quick Physical Exam Entry for Normal Findings

Vital Signs (1) <input type="checkbox"/> Reviewed	<input checked="" type="checkbox"/> T <input checked="" type="checkbox"/> P <input checked="" type="checkbox"/> R <input checked="" type="checkbox"/> SBP
Constitutional (1) <input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N WD <input type="checkbox"/> <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N WN <input type="checkbox"/> <input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N NAD <input type="checkbox"/>
Gen Appearance (1) <input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N Oriented x3 <input type="checkbox"/> - Credits under Psychiatric section -
Eyes (2) <input type="checkbox"/> Normal	<input checked="" type="checkbox"/> Y <input checked="" type="checkbox"/> N PERRL <input type="checkbox"/> <input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> N Sclera <input type="checkbox"/> <input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> N Conjunctiva <input type="checkbox"/>
ENT (2) <input type="checkbox"/> Normal	<input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> N TM's <input type="checkbox"/> <input checked="" type="checkbox"/> A <input checked="" type="checkbox"/> N Posterior Pharyngeal Wall <input type="checkbox"/>

Thyroid ☐
Cervical ☐ ☒ Y ☒ N Submandibular ☐
Wheezing ☐ ☒ Y ☒ N Rales ☐
Murmur ☐ ☒ Y ☒ N Rub ☐
S2 ☐ ☒ Y ☒ N S3 ☐
ND ☐ ☒ Y ☒ N BS Decreased ☐
Spleen ☐ ☒ A ☒ N Liver ☐
Testes ☐ ☒ A ☒ N Prostate ☐
Vagina ☐ ☒ A ☒ N Cervix ☐
Adnexae ☐ ☒ Y ☒ N CMT ☐
Palpation ☐ ☒ Y ☒ N Axillary Nodes Enlarged ☐
Bruising ☐
DTRs ☐ ☒ A ☒ N Balance ☐
Sensation ☐ ☒ A ☒ N Cerebellar ☐
Affect ☐
under Cardiovascular section -

S/O Text is *always* Medcin

Observation #2

Providers aren't willing to spend a lot of time
looking
for the “right” term

Clinical Data

Because providers aren't willing to spend a lot of time finding the exact Medcin term, anyone viewing the data shouldn't expect to find much specificity

Example:

- Paper note: "Patient had mild inspiratory wheezing in the left lower lung field"
- "Perfect" Medcin note: "Mild inspiratory wheezing. Wheezing was heard on the left at the base". 10+ mouse clicks
- Realistic Medcin note: "Wheezing was heard *in the left lower lung field with inspiration.*"

(All text in red is free-text)



Clinical Data

■ Worst case Medcin note:

Past, Social and Family Hx have 2 potential levels (pertinent and complete). A pertinent contains at least 1 type of history (Past, Social **or** Family) -> (99214)
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Learning and Understanding
☒ ☐ Learning Disability (barriers to learning)

Vitamins/Herbals/OTCs
☒ ☐ Taking Vitamin Supplements ☒ ☐ Taking OTC Medications ☐

Clinical Data

- Since providers won't spend time looking for terms, they will use the ones they *can* find easily **all** the time.
- If there is a term/concept that needs to be captured, it needs to be placed in a template that is being used
- Only AIM forms have “guaranteed” stability
- No system mechanism available to “mandate” any usage of the S/O module

Example of current Medcin use

Past, Social and Family Hx have 2 potential levels (pertinent and complete). A pertinent contains at least 1 type of history. A complete for a new patient requires all 3 types of history (Past, Social **and** Family) to be documented. None re

Past Medical History (1) Note: Any 1 of the 3 history items in burgundy will give 1 credit towards Past Hx

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Information Source: ☒ Patient ☐ Other:

- The “Current Medications” term is the same in all AMEDD AIM Forms
- There are queries that are run to check compliance with filling that box

Observation #3

Providers care considerably more about
the
quality of their documentation than they
do
about the codes generated



Clinical Data

- Are diagnoses (i.e. the ICD-9 codes) in AHLTA clinical data or business data?
- Is there a difference?
- Is there a 1:1 correspondence between diagnoses in a paper chart and diagnoses in AHLTA?

Clinical Data

- Diagnoses in the paper world
 - ▣ Providers could list diagnoses in any order
 - ▣ They could call a diagnosis whatever they wanted to
 - ▣ Coders never told a provider their diagnosis was “wrong”
 - ▣ Codes reflected what was in the documentation

- Today in AHLTA
 - ▣ There are rules for the ordering of diagnoses
 - What must be first, what must be one of the first 4, etc
 - ▣ Providers are limited on what they can directly call something
 - They aren’t limited to the ICD-9 text for what is printed
 - What’s available isn’t as robust as options with written notes
 - ▣ Providers are told that their documentation is wrong
 - They are told their code is wrong, but the code *is* the documentation

Clinical Data

Scenario #1: An 8 month old child is seen today because the doctor saw fluid in the middle ear a month ago and wanted to make sure it cleared after an infection. On exam today there is no fluid seen.

Paper chart: Assessment – s/p OM c effusion, now resolved. F/U at WCC in 1 month or PRN.

*sp OM c Effusion, Resolved
F/U @ WCC or PRN*

Scenario #1 (cont)

AHLTA Note:

1. Otitis Media

Comments: Effusion has resolved

1. Visit for: Follow-up Exam

Comments: s/p om w effusion, resolved

Added Frustration: The provider gets a different list of codes depending on if they search for “followup”, “follow up” or “follow-up”

Clinical Data

Scenario #2: 22 year old type 1 diabetic is 16 weeks pregnant and is coming in for a routine pre-natal visit. During the visit she complains of discharge and a GC probe is collected. It comes back from the lab positive for a Sexually Transmitted Disease.

- What do the coding rules say needs to be coded?
- What would the provider have written in the paper world?
- What is the incentive for the providers to do the extra work required to code above and beyond their documentation needs?

Business Data

Business Data

- There are three categories of codes that providers consider to be “business data”
 - ICD-9/10 codes (discussed previously)
 - CPT/HCPCS codes
 - E&M Codes

In the provider’s eyes, anything else is a very distant fourth

Procedure (or CPT) Codes

- Picked from Medcin terms, with a “many to one” mapping to CPT codes
 - E.g. both “Electrocardiogram” and “ECG 12-lead with interpretation and report” map to code 93000
 - The CPT code doesn’t end up on the note
- Providers *can* search for exact CPT codes if known
- Nearly all providers use templates or favorites lists to store their commonly used ones

Back to observation #2

“Providers aren’t willing to spend a lot of time looking for the right term”

- Providers will use what they can easily find, so once a code is in a template it is much more likely to be commonly used, *even if it’s the wrong code!*
- Work with the AHLTA training staff at your facility to help providers “clean up” the codes they shouldn’t be using out of their templates & favorites lists

HCPCS Codes

“Good Luck!”

- Observation #1 - “Metrics drive behavior”
- If there are no RVUs associated with a code, providers will not be *internally* motivated to capture it

Evaluation and Management (i.e. E&M) codes

■ Observation #1

■ Background

- E&M codes are a subset of all CPT codes that the DoD breaks out separate
- For many physicians, the vast majority of their RVUs come from their E&M codes
- AHLTA has an E&M calculator that works pretty well, provided it has data it understands
- AHLTA's E&M calculator doesn't include DoD-specific coding guidance (e.g. it doesn't force Medical Decision Making as a component for established patients)
- AHLTA's coding system has a number of "quirks"

Issues with the AHLTA Coding Calculator

- It can only use the 97 coding guidelines
- It can only count what it can “count”
 - The coding calculator can’t account for any data that is free-text
- It doesn’t ‘care’ about the nature of the presenting problem
- It does look at things a DoD coder is told not to look at

So what do providers do about their E&M codes?

- See “Observation #1”
- They would rather error on the side of “too high” than “too low”
- They pick the code they think is “right”
 - Especially if they have a lot of free text
- They click the “greater than 50% of time spent counseling and coordinating care” checkbox
 - Especially if they don’t want to write more free text

So how accurate is the coding calculator in AHLTA?

- Answer: “Great! As long as it has stuff to count.”
- Reality:
 - Most providers always override the suggested E&M code (see “Observation #1”)
 - Providers are much more likely to be praised for high RVUs than they are to be penalized for inaccurate coding (this also affects CPT coding)

Some Final Thoughts

- “Metrics Drive Behavior”
 - If a clinic looks at metrics for RVU generation (and trust me, they do) but they don’t care about (or even see) metrics on coding accuracy, it is unlikely that you will get providers to change current coding habits.
- “Providers aren’t willing to spend a lot of time looking for the ‘right’ term”
 - When looking at either clinical or business data, don’t expect a lot of specificity in the coded data. Providers want to finish their note, and if they can’t find something quickly they’ll pick anything and move on.
- “Provider care considerably more about the quality of their documentation than they do about the codes generated”
 - Proper training can help enable providers to generate quality notes that still provide the structured data needed by analysts at all levels.

Questions???

